# Alabama Medicaid Pharmacy
# Synagis® PA Request Form


**FAX: (800) 748-0116**
**Phone: (800) 748-0130**

**Fax or Mail to**
**HEALTH INFORMATION DESIGNS**

**P.O. Box 3210**
**Auburn, AL 36832-3210**


## PATIENT INFORMATION

Patient Name _____ Patient Medicaid # _____

Patient DOB _____ Patient phone # with area code _____

## PRESCRIBER INFORMATION

Prescriber name _____ NPI # _____ License # _____

Phone # with area code _____ Fax # with area code _____

Address (Optional) _____
(Address/City/State/Zip)

***I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.***

_____
**Prescribing Practitioner Signature** **Date**

## DRUG/CLINICAL INFORMATION

Drug requested _____ Strength _____

J Code _____ (if applicable) Qty. per month _____ NDC # _____

Diagnosis or ICD-9 Code* _____ Diagnosis or ICD-9 Code* _____

Current weight _____ kg. Number of doses requested _____

(Check applicable age, condition and risk factors)

- ❒ Gestational age ≤ 28 wks & infant is < 12 months†
- ❒ Gestational age 29-32 wks & infant is < 6 months†
- ❒ Gestational age 33-35 wks & infant < 6 months† with AAP risk factors**
  **AND**
- ❒ Currently outpatient with no inpatient stay in the last 2 weeks.
- ❒ Child is < 24 months† old with Chronic Lung Disease*
- ❒ Child is ≤ 24 months† old with Congenital Heart Disease*

* Include ICD-9 codes for the indicated disease state
** Document AAP risk factor(s) and/or other required medical justification.
† Chronological age at start of RSV season.

**Medical justification** _____

_____

**❒ Additional medical justification attached.**

❒ A dose of Synagis® was administered while patient was hospitalized. Date dose administered _____

## PHARMACY INFORMATION

Dispensing pharmacy _____ NPI# _____

Phone # with area code _____ Fax # with area code _____

## FOR HID USE ONLY

❒ Approve request ❒ Deny request ❒ Modify request ❒ Medicaid eligibility verified

Comments _____

_____

Reviewer's Signature Response Date/Hour